Based upon available data, the average for July 1, 1997 was $113.45 per resident day, which will comprise the swing bed rate for October 1, 1998 through June 30, 1999. The same methodology shall be followed for subsequent swing bed rates as well.

Section XIV. Correction of MDS Data for Determination of Direct Care Component Rates:

As noted above, individual resident clinical and other data from nursing facility-completed resident assessment instruments (Minimum Data Set or MDS data) for the facility's entire population and for its Medicaid resident population is used to help determine and update direct care component rates.

("P & I")

In order to ensure correct MDS data for rate setting, while meeting requirements imposed by HCFA, the department has explored a number of possible approaches and eliminated some.

Under the approach selected by the department, the department will become an "agent" for all the state's Medicaid nursing facilities to collect and transmit facility-generated resident assessment data to the HCFA system, as allowed by HCFA data submission specifications.

The state will perform no edit checks and will make no changes to assessment data prior to forwarding it to the HCFA system. However, all assessments not passing state specifications will be rejected for case mix purposes and facilities will be required to make necessary corrections before the data is accepted for case mix.

These state-mandated corrections will be flagged as resubmissions and will not be forwarded to the HCFA system or reflected in HCFA's data in any way. There will then be two data bases. Facilities will be allowed to make corrections to all assessments submitted back to June 1, 1998 and direct care component rates will be retroactively corrected as needed.

Section XV. 1997 Balanced Budget Act, Section 4711 -- Public Process for Changes to Nursing Facility Medicaid Payment Rates:

For all material changes to the methodology for determining nursing facility Medicaid payment rates occurring after October 1, 1997, requiring a state plan amendment, the state's Medicaid agency, the Department of Social and Health Services, shall follow the following public process:

(1) The proposed estimated payment rates, the proposed new methodologies for determining payment rates, and the underlying justifications shall be published. Publication shall be: (a) in the Washington State Register; or (b) in the Seattle Times and Spokane Spokesman Review newspapers.

(2) The department shall maintain and update as needed a mailing list of all individuals and organizations wishing to receive notice of changes to the nursing facility Medicaid payment rate methodology, and all materials submitted for publication shall be sent postage prepaid by regular mail to such individuals and organizations as well.

(3) Nursing facility providers, their associations, nursing

facility Medicaid beneficiaries, representatives, and other concerned members of the public shall be given a reasonable opportunity to review and comment on the proposed estimated rates, methodologies and justifications. The period allowed for review and comment shall not be less than fourteen (14) calendar days after the date of the Washington State Register containing the published material or the date the published material has appeared in both the Seattle Times and Spokane Spokesman Review.

(4) After receiving and considering all comments, if the department decides to move ahead with a change or changes to its nursing facility payment rate methodologies, it shall adopt needed further changes in response to comments, if any, and shall publish the final estimated rates, final rate determination methodologies and justifications. Publication shall be: (a) in the Washington State Register; or (b) in the Seattle Times and Spokane Spokesman Review newspapers. Unless an earlier effective date is required by state or federal law, implementation of final changes in methodologies and commencement of the new rates shall not occur until final publication in the Register has occurred or publication in both designated newspapers has occurred. The department shall not be authorized to delay implementation of, or to alter, ignore or violate requirements of, state or federal laws in response to public process comments.

Section XVI. Proportionate Share Payments for Nursing Facilities Operated by Public Hospital Districts:

A proportionate share pool is created each state fiscal year for supplemental payments to eligible providers of Medicaid nursing facility services. Eligible providers are public
"P & I" hospital districts that operate nursing facilities.

Funds retained by the districts will be used to improve access to health care in rural areas at nursing facilities. Federal matching funds resulting from the supplemental payments to the districts shall be used for important state health care needs.

"P & I"

"P & I" The supplemental payments made to public hospital districts are subject to prior federal approval for obtaining federal matching funds for the supplemental payments to the districts, legislative appropriations for the supplemental payments, a contractual commitment by each hospital district to return a minimum of 82% by intergovernmental transfer to the state treasurer for deposit in the health services account, and a contractual commitment by the districts to not allow expenditures covered by the supplemental
"P & I" payments to be included in costs used to set Medicaid nursing facility payment rates.

The supplemental payments shall not be subject to rules governing settlement (payment at lower of cost or rate), or to rules governing rates contained in chapter 74.46 RCW and WAC 388-96 WAC. However, they are subject to the federal Medicare upper limit for
"P & I" nursing facility payments. The Medicare upper limit analysis will be performed prior to making the supplemental payments

"P & I" Payments will be distributed directly to the public hospital districts in proportion to the number of Medicaid days of care provided by each district in the preceding calendar year, relative to the total Medicaid days of care provided by districts statewide during the same
"P & I" year. The supplemental payments will be made once in each federal fiscal year, beginning federal fiscal year 1999.

State of Washington

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **Washington**
Part 2: - Intermediate Care Facility for the Mentally Retarded Services

Reimbursement for services provided by Intermediate Care Facilities for the mentally retarded (ICFs/MR) for Medicaid recipients is made by rates determined per the following principles, methods, and standards which comply with federal statutory and regulatory requirements.

I. REIMBURSEMENT PRINCIPLES

A. Medicaid rates are established pursuant to Revised Code of Washington (RCW), Washington Administrative Code (WAC), and Division Policy Directives.

B. Payment rates for non state owned intermediate care facilities for the mentally retarded, hereafter called ICF/MRs, are comprised of three cost center prospective rate components which are: Resident Care and Habilitation (RCH); Administration, Operations and Property (AO and P); and Return on Equity (ROE). Payment rates for state owned facilities, hereafter called Resident Habilitation Centers (RHCs), are their allowable costs.

C. Data used for establishing ICF/IMR prospective rates is from providers' most recent cost reports and cost center cost rates. Data used for setting RHC interim rates is based on the RHCs' most recent cost reports.

D. Cost report data is desk-reviewed to determine that it is correct, complete and reported in conformity with generally accepted accounting principles, and WAC provisions.

E. Allowable costs are documented costs which are ordinary, necessary, and related to care of Title XIX program residents, and which must be incurred by efficiently and economically operated service providers in conformity with applicable state and federal laws, regulations, and quality and safety standards.

II. ICF/MR RATES

A. Prospective Rates

1. The prospective rate for each provider is computed on a resident day basis. The rate is the total of three cost center rates: Resident Care and Habilitation (RCH); Administration, Operations and Property (AO and P); and Return on Equity (ROE).

2. Rates are prospective, subject to settlement in the Resident Care and Habilitation component at the lower of cost or rate, and are individually computed for each non-state owned ICF/MR facility. Rates are settled on a calendar year basis by comparison of the Residential Care and Habilitation rate component to the corresponding costs it was intended to address. Each provider is issued a preliminary settlement for each calendar year and, if an audit is done, a final settlement. A final settlement, if one is issued, incorporates the audit results and supersedes the preliminary settlement. The total rate after the settlement process (called the "settlement rate") represents the final reimbursement rate of the provider for the calendar settlement year in question.

3. Prospective rates are based upon reported costs of a provider for the most recent calendar year. Prospective rates are reset each July 1st utilizing reported costs from the preceding calendar year, after they have been desk reviewed and adjusted. These rates remain in effect until June 30th of the following year except that they are subject to revisions or adjustment for specific circumstances as described below.

B. Inflation Adjustments

1. New rates reflect inflationary cost increases between the most recent and next prior calendar years because rates are based essentially on the most recent calendar year reported costs. In addition, the department is authorized to increase new rates by an add-on inflation factor subject to the Administration and Operations cost center lid as described in subparagraph II.E.2.b. The Property component of the Administration, Operations and Property cost center and the Return of Equity cost center are not subject to inflation adjustments.

2. The adjusted and allowable costs in the Resident Care and habilitation cost center (except for costs relating to resident care and training (RCT) and recreation personnel) and the Administration and Operations components of the Administration, Operations, and Property cost center are adjusted for inflation based on the Implicit Price Deflator For Personal Consumption published by the U.S. Department of Commerce, Bureau of Economic Analysis.

C. Allowable Costs

Allowable costs are documented costs not expressly declared unallowable which are necessary, ordinary and related to the care of Title XIX program recipients. The Washington system does not guarantee that all allowable costs in any particular period will by fully reimbursed.

D. Resident Care and Habilitation Cost Area Rate

The resident care and habilitation cost center rate reimburses for resident living services, habilitation and training services, recreational services and nursing services in accordance with applicable state and federal regulations. A provider's July 1, rate is the sum of the following:

1. The provider's most recent desk-reviewed costs per resident day (except those costs for resident care and training (RCT) and recreation staff and purchased services) from the most recent calendar year cost report, adjusted for inflation as described in section II.B., divided by the provider's total adjusted number of resident days.

2. The provider's total RCT and recreation staff and purchased service cost per hour, adjusted for inflation as described in section II.B., times the adjusted number of paid hours worked during the rate period, divided by the provider's total adjusted number of resident days.

E. Administration, Operations and Property Area Rate

The administration, operations and property cost center rate is comprised of three components: food component rate; administration and operations component rate; and property component rate.

1. The food component rate reimburses for costs of bulk and raw food, dietary supplements and beverages. The rate is a flat rate for all providers based upon the July 1, 1983 IMR food cost center rate of $3.12 per resident day for all providers increased by the inflation factors granted in each rate period since that time.

2. The administration and operations component rate reimburses for costs of overall administration and management of the facility, operation and maintenance of the physical plant, resident transportation, dietary service (other than the cost of food and beverages), laundry service, medical and habilitative supplies, taxes and insurance. A provider's rate is the lessor of:

   a. The provider's desk-reviewed administration and operations costs per total resident day, adjusted for inflation and for the period April 1, 1992 through June 30, 1992, a prospective rate adjustment for tax costs levied on total revenue received for ICF/MR services; or,

   b. The eighty-fifth percentile ranking of ICF/MR and RHC providers' desk-reviewed administration and operations costs per total resident day, adjusted for inflation plus the amount of the prospective rate adjustment for tax costs as described in subparagraph II.E.2.a. The ranking is based on the most recent ICF/MR and RHC cost reports submitted on or before the effective date of the rate period (July 1) for facilities having an occupancy level of at least eighty-five percent for the cost report period.

c. For establishing a provider's desk-reviewed administration and operations costs, certain administrative personnel, management agreements, and central office services are subject to maximum compensation limits prescribed in Washington Administrative Code (WAC) provisions and Division Policy.

3. The property component rate reimburses for costs of depreciation, interest, and leases of buildings, equipment, and vehicles required in the provision of IMR services. For establishing a provider's desk-reviewed property component costs, depreciation for building, land improvements, and fixed equipment is limited to the straight-line depreciation method. A provider's property component rate is the provider's desk-reviewed property cost from their most recent cost report divided by their total adjusted number of resident days.

Effective October 1, 1984, the depreciation base for assets acquired in a change of ownership entered into on or after July 18, 1984 shall not exceed the lower of the purchase price to the new owner or the allowable acquisition cost base to the first owner of record of the assets on or after July 18, 1984. Costs (including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of the assets acquired in the change of ownership, where any payment has previously been made by Title XIX, shall not be allowed.

Effective October 1, 1984, allowable debt and interest related to assets acquired in a change of ownership entered into on or after July 18, 1984 shall be the actual debt and interest, except that the rate of interest is limited to the lower of the actual rate of interest or the rate of return on equity related to the acquired assets times the ratio obtained by dividing the allowable acquisition cost base to the new owner (equal to the allowable depreciation base as previously noted) by the purchase price of the assets to the new owner. Debt and interest related to costs (including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies) attributable to negotiation or settlement of the sale or purchase of the acquired assets in the change of ownership, where any payment has previously been made by Title XIX, shall not be allowed.

Effective October 1, 1984, assets acquired in a change of ownership entered into on or after July 18, 1984, are subject to the following depreciation recapture provisions:

a. A gain or loss on the retirement of an asset shall be the difference between the remaining undepreciated base and any proceeds received for, or to compensate for the loss of, the asset. If the retired asset is replaced, the gain or loss shall be spread over the actual life. of the asset up to the date of retirement, provided the provider has made a reasonable effort to recover at least the outstanding book value of the asset.

b. If a contractor terminates participation in the program, the department shall recover excess reimbursed depreciation for an asset. Excess reimbursed depreciation is the difference between reimbursement actually paid for depreciation of the asset minus the basis for depreciation of the asset, not to exceed the reimbursement actually paid for depreciation. The basis for depreciation is the difference between the historical cost of the asset minus the sale price of the asset. The basis for depreciation will be adjusted for the period under the program.

F. Return on Equity Component Rate

Proprietary providers are eligible for return on equity. Equity is based upon Medicate rules and regulations (42 CFR 413.157), except that goodwill is not included in determining net equity. Net equity is comprised of a provider's working capital plus equity in assets as of the last day of the most recent calendar year, computed as follows:

1. Working capital is calculated as current assets less current liabilities.